

Name _____ Address _____ Tel _____ Fax _____ Billing No. _____			Laboratory Use Only				
Name _____ Address _____ Tel _____ Fax _____ Billing No. _____			Patient Last Name _____		Date of Birth YYYY / MM / DD		
Name _____ Address _____ Tel _____ Fax _____ Billing No. _____			Patient First and Middle Names (on Health Card) _____		Patient Telephone Number _____		
Patient Chart Number _____			Health Card Number _____		Version _____ Province _____ Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X		
Date Specimen(s) Obtained YYYY / MM / DD			<input type="checkbox"/> Third Party / Uninsured		<input type="checkbox"/> Workplace Safety and Insurance Board (WSIB)		
Specimen	Anatomic Site and Procedure	Clinical Data (diagnosis/differential diagnosis/LMP for gyn specimens)					
A	Site Name _____ <input type="checkbox"/> Excision <input type="checkbox"/> Punch Biopsy <input type="checkbox"/> Curettage <input type="checkbox"/> Shave Biopsy <input type="checkbox"/> Other (Specify): _____	Time removed _____ Time placed in formalin _____					
B	Site Name _____ <input type="checkbox"/> Excision <input type="checkbox"/> Punch Biopsy <input type="checkbox"/> Curettage <input type="checkbox"/> Shave Biopsy <input type="checkbox"/> Other (Specify): _____	Time removed _____ Time placed in formalin _____					
C	Site Name _____ <input type="checkbox"/> Excision <input type="checkbox"/> Punch Biopsy <input type="checkbox"/> Curettage <input type="checkbox"/> Shave Biopsy <input type="checkbox"/> Other (Specify): _____	Time removed _____ Time placed in formalin _____					
D	Site Name _____ <input type="checkbox"/> Excision <input type="checkbox"/> Punch Biopsy <input type="checkbox"/> Curettage <input type="checkbox"/> Shave Biopsy <input type="checkbox"/> Other (Specify): _____	Time removed _____ Time placed in formalin _____					
E	Site Name _____ <input type="checkbox"/> Excision <input type="checkbox"/> Punch Biopsy <input type="checkbox"/> Curettage <input type="checkbox"/> Shave Biopsy <input type="checkbox"/> Other (Specify): _____	Time removed _____ Time placed in formalin _____					
F	Site Name _____ <input type="checkbox"/> Excision <input type="checkbox"/> Punch Biopsy <input type="checkbox"/> Curettage <input type="checkbox"/> Shave Biopsy <input type="checkbox"/> Other (Specify): _____	Time removed _____ Time placed in formalin _____					
G	Site Name _____ <input type="checkbox"/> Excision <input type="checkbox"/> Punch Biopsy <input type="checkbox"/> Curettage <input type="checkbox"/> Shave Biopsy <input type="checkbox"/> Other (Specify): _____	Time removed _____ Time placed in formalin _____					
H	Site Name _____ <input type="checkbox"/> Excision <input type="checkbox"/> Punch Biopsy <input type="checkbox"/> Curettage <input type="checkbox"/> Shave Biopsy <input type="checkbox"/> Other (Specify): _____	Time removed _____ Time placed in formalin _____					
Total number of containers submitted with this requisition _____			Physician/practitioner Signature _____				
Laboratory Use Only							